

# PostScript

## LETTERS

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### Perforating chancre: any cause-effect relation with HIV infection?

Variation in clinical pictures of syphilis, when co-infected with HIV are well known.<sup>1</sup> Normally, a classic Hunterian chancre heals within 1-2 weeks of treatment without scarring.<sup>2</sup> Primary chancre, healing with perforation of the site, does not commonly occur.<sup>3</sup> Here we report four patients with primary syphilis, in whom the chancres healed with perforation of the genitalia. Concomitant infection with HIV is presumed to be responsible for this destructive sequela.

#### Case 1

A 21 year old woman presented with a painless, indurated ulcer on the inner aspect of the left labia majora, along with same sided inguinal lymphadenopathy of 1 week's duration. Dark ground microscopy (DGI) was positive for *Treponema pallidum* and VDRL titre was 1:64. Following treatment with penicillin, the ulcer healed slowly, leaving a perforation on the labia majora.

#### Case 2

A 20 year old unmarried male patient with high risk behaviour presented with a painless indurated ulcer over the dorsal aspect of the prepuce and unilateral inguinal lymphadenopathy. DGI was positive for *T. pallidum* and VDRL titre was 1:32. He had a history of genital ulceration and was treated for suspected lymphogranuloma venereum. Following treatment with penicillin, the ulcer healed at a slower pace leaving a large perforation on the prepuce (fig 1).

#### Case 3

A 23 year old unmarried man, with a history of repeated unprotected exposure to commercial sex workers, presented with a painless, indurated ulcer on the dorsal prepuce, multiple genital mollusca contagiosa, and genital warts.



Figure 1 Perforation of prepuce.

Bilateral inguinal lymphadenopathy was present. DGI from the ulcer was negative and VDRL was 1:64. Following penicillin therapy, it healed with perforation of the prepuce.

#### Case 4

A 45 year old married man with high risk behaviour presented with a large perforation on the lateral side of the shaft of the penis. He gave a history of a painless ulcer on the same site about 1 month earlier. At presentation, his VDRL was 1:32. He was treated with penicillin.

#### Comment

Gram stained smears from the ulcers and culture for aerobic and anaerobic organisms were negative in first three cases. In all the four patients, ELISA for HIV was positive.

Immune response to *T. pallidum* is primarily cell mediated.<sup>2</sup> In an immunocompetent host with primary syphilis, CD4+:CD8+ T lymphocyte ratio is high at the site of the chancre,<sup>2</sup> which possibly prevents local multiplication of the organism. Consequent to the loss of local cellular immunity as a result of HIV infection there may be an enhanced ability of the organism to multiply locally, giving rise to larger and deeper ulcers which are slower to heal. This fact has been demonstrated experimentally in animal models.<sup>4</sup>

Studies exploring the correlation of CD4+ T cell count and stage of HIV infection with this altered manifestation of primary syphilis should be undertaken. This might show the impact of HIV infection on the clinical severity of primary chancre.

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## References

- 1 Musher DM, Hamill RJ, Raughn RE. Effect of human immunodeficiency virus (HIV) infection on the course of syphilis and on the response to treatment. *Ann Intern Med* 1990;113:872-81.
- 2 Sanchez MR. Syphilis. In: Freedberg IM, Eisen AZ, Wolff KW, et al, eds. *Fitzpatrick's dermatology in general medicine*. Vol 2. 5th ed. New York: McGraw-Hill, 1999:2551-80.
- 3 Pavithran K. Perforating syphilitic chancre. *Indian J Dermatol Venereol Leprol* 1987;53:352-4.
- 4 Marra CM, Handsfield NH, Kuller L, et al. Alterations in the course of experimental syphilis associated with concurrent simian immunodeficiency virus infection. *J Infect Dis* 1992;165:1020-5.

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### Superior mesenteric artery syndrome in an HIV positive patient

A 27 year old HIV positive man with a CD4+ lymphocyte count of 26 cells  $\times 10^6/l$  presented with a 2 week history of progressive left sided weakness, vomiting, and weight loss. A computed tomograph (CT) brain scan demonstrated ring lesions bilaterally in the basal ganglia. Toxoplasma serology was positive at a titre of 1:256 and treatment for cerebral toxoplasmosis commenced. His weakness responded to therapy but vomiting continued despite antiemetics. An ultrasound scan demonstrated an enlarged, dilated stomach, dilated first and second parts of the duodenum, and an obstruction at the level of the third. Barium studies confirmed these findings but also demonstrated prominent peristalsis in the second part of the duodenum and an abrupt cessation of flow to barium in the middle of the third (fig 1). Some flow of barium into the jejunum was noted when the patient was turned prone. An abdominal CT scan demonstrated a reduction in the angle between the superior mesenteric artery and the aorta (fig 2). A diagnosis of superior mesenteric artery (SMA) syndrome was considered. Two litres of bile were aspirated per nasogastric tube daily and he continued to lose weight. His body mass index (BMI) fell to

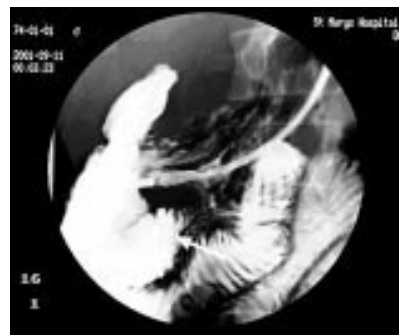


Figure 1 Image from barium meal series. The proximal duodenum is dilated. There is an abrupt calibre change (arrow) in the third part where the superior mesenteric artery crosses. Distinct peristalsis was seen in this region during the study.